

Welcome

Thank you for selecting our dental healthcare team!
We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

Patient Information (CONFIDENTIAL)

Name _____ Birthdate _____ Date _____
Address _____ City _____ SS#/SIN _____
Email _____ Home Phone _____
Cell Phone _____
State/Prov. _____ Zip/P.C. _____

Check Appropriate Box: Minor Single Married Divorced Widowed Separated

Patient or Parent/Guardian's Employer _____ Work Phone _____
Business Address _____ City _____ State/Prov. _____ Zip/P.C. _____
Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____
Whom may we thank for referring you? _____
Person to contact in case of emergency _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____
Address _____ Home Phone _____
Email _____ Cell Phone _____
Driver's License# _____ Birthdate _____
Employer _____ Work Phone _____ SS#/SIN _____

Is this person currently a patient in our office? Yes No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

Cash Check VISA MasterCard Discover American Express I wish to discuss the office's payment policy.

Insurance Information

Name of Insured _____ Relationship to Patient _____
Birthdate _____ SS#/SIN _____ Date Employed _____
Name of Employer _____ Union or Local# _____ Work Phone _____
Address of Employer _____ City _____ State/Prov. _____ Zip/P.C. _____
Insurance Company _____ Group# _____ Policy/ID# _____
Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C. _____
How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? Yes No IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____
Birthdate _____ SS#/SIN _____ Date Employed _____
Name of Employer _____ Union or Local# _____ Work Phone _____
Address of Employer _____ City _____ State/Prov. _____ Zip/P.C. _____
Insurance Company _____ Group# _____ Policy/ID# _____
Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C. _____
How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____

Over Please

Medical History

Mt. Graham Dental Associates

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Are you under a physician's care now? Yes No If yes, please explain: _____
- Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: _____
- Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____
- Are you taking any medications, pills, or drugs? Yes No If yes, please explain: _____
- Do you take, or have you taken, Phen-Fen or Redux? Yes No _____
- Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No _____
- Are you on a special diet? Yes No
- Do you use tobacco? Yes No
- Do you use controlled substances? Yes No

Women: Are you

- Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?

- Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfa drugs
- Other If yes, please explain: _____

Do you have, or have you had, any of the following?

- | | | | | | | | |
|---------------------------|--|---------------------------|--|-----------------------|--|----------------------------|--|
| AIDS/HIV Positive | <input type="radio"/> Yes <input type="radio"/> No | Cortisone Medicine | <input type="radio"/> Yes <input type="radio"/> No | Hemophilia | <input type="radio"/> Yes <input type="radio"/> No | Radiation Treatments | <input type="radio"/> Yes <input type="radio"/> No |
| Alzheimer's Disease | <input type="radio"/> Yes <input type="radio"/> No | Diabetes | <input type="radio"/> Yes <input type="radio"/> No | Hepatitis A | <input type="radio"/> Yes <input type="radio"/> No | Recent Weight Loss | <input type="radio"/> Yes <input type="radio"/> No |
| Anaphylaxis | <input type="radio"/> Yes <input type="radio"/> No | Drug Addiction | <input type="radio"/> Yes <input type="radio"/> No | Hepatitis B or C | <input type="radio"/> Yes <input type="radio"/> No | Renal Dialysis | <input type="radio"/> Yes <input type="radio"/> No |
| Anemia | <input type="radio"/> Yes <input type="radio"/> No | Easily Winded | <input type="radio"/> Yes <input type="radio"/> No | Herpes | <input type="radio"/> Yes <input type="radio"/> No | Rheumatic Fever | <input type="radio"/> Yes <input type="radio"/> No |
| Angina | <input type="radio"/> Yes <input type="radio"/> No | Emphysema | <input type="radio"/> Yes <input type="radio"/> No | High Blood Pressure | <input type="radio"/> Yes <input type="radio"/> No | Rheumatism | <input type="radio"/> Yes <input type="radio"/> No |
| Arthritis/Gout | <input type="radio"/> Yes <input type="radio"/> No | Epilepsy or Seizures | <input type="radio"/> Yes <input type="radio"/> No | High Cholesterol | <input type="radio"/> Yes <input type="radio"/> No | Scarlet Fever | <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Heart Valve | <input type="radio"/> Yes <input type="radio"/> No | Excessive Bleeding | <input type="radio"/> Yes <input type="radio"/> No | Hives or Rash | <input type="radio"/> Yes <input type="radio"/> No | Shingles | <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Joint | <input type="radio"/> Yes <input type="radio"/> No | Excessive Thirst | <input type="radio"/> Yes <input type="radio"/> No | Hypoglycemia | <input type="radio"/> Yes <input type="radio"/> No | Sickle Cell Disease | <input type="radio"/> Yes <input type="radio"/> No |
| Asthma | <input type="radio"/> Yes <input type="radio"/> No | Fainting Spells/Dizziness | <input type="radio"/> Yes <input type="radio"/> No | Irregular Heartbeat | <input type="radio"/> Yes <input type="radio"/> No | Sinus Trouble | <input type="radio"/> Yes <input type="radio"/> No |
| Blood Disease | <input type="radio"/> Yes <input type="radio"/> No | Frequent Cough | <input type="radio"/> Yes <input type="radio"/> No | Kidney Problems | <input type="radio"/> Yes <input type="radio"/> No | Spina Bifida | <input type="radio"/> Yes <input type="radio"/> No |
| Blood Transfusion | <input type="radio"/> Yes <input type="radio"/> No | Frequent Diarrhea | <input type="radio"/> Yes <input type="radio"/> No | Leukemia | <input type="radio"/> Yes <input type="radio"/> No | Stomach/Intestinal Disease | <input type="radio"/> Yes <input type="radio"/> No |
| Breathing Problem | <input type="radio"/> Yes <input type="radio"/> No | Frequent Headaches | <input type="radio"/> Yes <input type="radio"/> No | Liver Disease | <input type="radio"/> Yes <input type="radio"/> No | Stroke | <input type="radio"/> Yes <input type="radio"/> No |
| Bruise Easily | <input type="radio"/> Yes <input type="radio"/> No | Genital Herpes | <input type="radio"/> Yes <input type="radio"/> No | Low Blood Pressure | <input type="radio"/> Yes <input type="radio"/> No | Swelling of Limbs | <input type="radio"/> Yes <input type="radio"/> No |
| Cancer | <input type="radio"/> Yes <input type="radio"/> No | Glaucoma | <input type="radio"/> Yes <input type="radio"/> No | Lung Disease | <input type="radio"/> Yes <input type="radio"/> No | Thyroid Disease | <input type="radio"/> Yes <input type="radio"/> No |
| Chemotherapy | <input type="radio"/> Yes <input type="radio"/> No | Hay Fever | <input type="radio"/> Yes <input type="radio"/> No | Mitral Valve Prolapse | <input type="radio"/> Yes <input type="radio"/> No | Tonsillitis | <input type="radio"/> Yes <input type="radio"/> No |
| Chest Pains | <input type="radio"/> Yes <input type="radio"/> No | Heart Attack/Failure | <input type="radio"/> Yes <input type="radio"/> No | Osteoporosis | <input type="radio"/> Yes <input type="radio"/> No | Tuberculosis | <input type="radio"/> Yes <input type="radio"/> No |
| Cold Sores/Fever Blisters | <input type="radio"/> Yes <input type="radio"/> No | Heart Murmur | <input type="radio"/> Yes <input type="radio"/> No | Pain in Jaw Joints | <input type="radio"/> Yes <input type="radio"/> No | Tumors or Growths | <input type="radio"/> Yes <input type="radio"/> No |
| Congenital Heart Disorder | <input type="radio"/> Yes <input type="radio"/> No | Heart Pacemaker | <input type="radio"/> Yes <input type="radio"/> No | Parathyroid Disease | <input type="radio"/> Yes <input type="radio"/> No | Ulcers | <input type="radio"/> Yes <input type="radio"/> No |
| Convulsions | <input type="radio"/> Yes <input type="radio"/> No | Heart Trouble/Disease | <input type="radio"/> Yes <input type="radio"/> No | Psychiatric Care | <input type="radio"/> Yes <input type="radio"/> No | Venereal Disease | <input type="radio"/> Yes <input type="radio"/> No |
| | | | | | | Yellow Jaundice | <input type="radio"/> Yes <input type="radio"/> No |

Have you ever had any serious illness not listed above? Yes No

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

- | | | | |
|--|--|--|--|
| 1. Do your gums bleed while brushing or flossing?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | 7. Have you ever experienced any of the following problems in your jaw? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Are your teeth sensitive to hot or cold liquids/foods?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | Clicking..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Are your teeth sensitive to sweet or sour liquids/foods?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pain (joint, ear, side of face)..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Do you feel pain to any of your teeth?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | Difficulty in opening or closing..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Do you have any sores or lumps in or near your mouth?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | Difficulty in chewing..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Have you had any head, neck or jaw injuries?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | 8. Do you have frequent headaches?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | 9. Do you clench or grind your teeth?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | 10. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X
Signature of patient (or parent/guardian if minor) _____ Date _____